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Office of Administrative Law Judges
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Issue Date: 31 July 2007

In the Matter of:

I.C.,
Survivor of E.C.,
Claimant

Case No.: 2004-BLA-6370

v.

SHAMROCK COAL COMPANY, INC.,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Edmond Collett, Esq.
Edmond Collett, P.S.C.
Hyden, Kentucky
For the Claimant

Lois A. Kitts, Esq.
Baird &Baird
Pikeville, Kentucky
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER DENYING REQUEST FOR MODIFICATION

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901, *et seq*. The Act and implementing regulations, 20 CFR Parts 410, 718, 725, and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C.

§ 902(b); 20 CFR § 718.201 (2006). In this case, the Claimant alleges that she is the surviving dependent of a miner whose death was due to pneumoconiosis.

I conducted a hearing on this claim on April 4, 2006, in Hazard, Kentucky. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2006). The Director of the Office of Workers' Compensation Programs (OWCP) was not represented at the hearing. For the purpose of the hearing, I ruled that the claim should be treated as a request for modification of the denial of the Claimant's initial claim filed in 1999, and that the evidentiary limitations contained in the current rules do not apply. Transcript ("Tr.") 10. The Claimant was the only witness. Tr. 16-23. Director's Exhibits ("DX") 1-212 and Employer's Exhibits ("EX") 1-7 were admitted into evidence without objection. Tr. 13-15. The record was held open after the hearing to allow the parties to consult regarding the procedural status of the case and whether to supplement the record, and to submit closing arguments. The Claimant and Employer submitted closing arguments, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record, including all exhibits, the testimony at hearing, and the arguments of the parties.

PROCEDURAL HISTORY

The Miner filed his initial claim on May 7, 1979. DX 1. On January 21, 1987, Administrative Law Judge Robert D. Kaplan issued a Decision and Order denying benefits. DX 43. Judge Kaplan found that the Miner had not established that he had pneumoconiosis, or that he was totally disabled due to pneumoconiosis. The Miner appealed, and the Benefits Review Board (the "Board") affirmed Judge Kaplan's denial of benefits on September 30, 1988. DX 54.

Less than one year later, on September 6, 1989, the Miner filed a request for modification. DX 55. The request for modification was finally denied on June 29, 1995, when the Board affirmed Administrative Law Judge John C. Holmes' denial of modification on remand. DX 111, 124. Judge Holmes found that the Miner had failed to establish that he was totally disabled due to pneumoconiosis. DX 100.

The Miner filed another request for modification on March 1, 1996. DX 117. This request for modification was also heard by Judge Holmes, who issued a Decision and Order Denying Modification on March 17, 1997. Judge Holmes again held that the Miner's pulmonary impairment was not due to coal dust exposure. DX 142. The Board affirmed Judge Holmes' denial of modification in a Decision and Order dated March 20, 1998. DX 149.

Less than one year later, on August 12, 1998, the Miner filed another request for modification. DX 150. The request was denied by the District Director, OWCP, on October 9, 1998. DX 155. The Miner died on January 9, 1999.

The Claimant filed her initial claim on February 1, 1999. DX 160. When the District Director denied her claim as well, she appealed both claims. Administrative Law Judge Rudolf L. Jansen entered a Decision and Order denying benefits in both the Miner's claim, and the Survivor's claim, on July 24, 2000. DX 181. Judge Jansen found that the Claimant had failed to establish a change in conditions or a mistake of fact justifying modification in the

Miner's claim. In the Survivor's claim, Judge Jansen found that the Claimant had not only failed to establish that the Miner had pneumoconiosis, but also, even if it existed, she had failed to establish that pneumoconiosis hastened the Miner's death in any way. The Claimant appealed this decision to the Board. The Board affirmed Judge Jansen's denial of benefits in both claims in a Decision and Order issued August 24, 2001. DX 181 (DX 193).

On April 10, 2002, the Claimant filed a Motion to Voluntarily Withdraw her Survivor's claim. On April 19, 2002, the Director granted the motion. The Employer filed a Motion for Reconsideration of Proposed Decision and Order Withdrawal of Claim on April 26, 2002. However, the Director declined to reconsider and stated it was in the widow's best interest to withdraw the claim and file a new claim. The Employer appealed this decision directly to the Benefits Review Board. However, the Director filed a Motion to Dismiss the Appeal, which the Board granted on December 18, 2002, finding that it had no jurisdiction to consider the appeal. DX 181.

In the meantime, on June 26, 2002, the Claimant had filed a new Survivor's claim. DX 182. The Director issued a proposed Decision and Order denying benefits on December 10, 2003. DX 205. The Claimant appealed, but after the claim was referred to the Office of Administrative Law Judges, the Employer filed a motion to remand the claim to the District Director to further develop the record. DX 181. Administrative Law Judge Daniel J. Roketenetz issued an Order of Remand on February 23, 2004. DX 181 (DX 181). On March 5, 2004, the District Director, OWCP, notified the parties that the Claimant's two claims had been consolidated, and would be returned to the Office of Administrative Law Judges; the only issue in the first claim would be whether or not the District Director appropriately allowed withdrawal of the claim. DX 181. The consolidated claims were referred to the Office of Administrative Law Judges for hearing on June 3, 2004. DX 210. For the reasons stated below, I have determined that the withdrawal was improper, and the Claimant's 2002 claim should be treated as a request for modification.

APPLICABLE STANDARDS

This case pertains to a request for modification of an adverse decision of a survivor's claim filed on February 1, 1999. Because the claim at issue was filed after March 31, 1980, the regulations at 20 CFR Part 718 apply. 20 CFR § 718.2 (2006). Parts 718 (standards for award of benefits) and 725 (procedures) of the regulations underwent extensive revisions effective January 19, 2001. 65 Fed. Reg. 79920 et seq. (2000). The Department of Labor has taken the position that as a general rule, the revisions to Part 718 should apply to pending cases because they do not announce new rules, but rather clarify or codify existing policy. See 65 Fed. Reg. at 79949-79950, 79955-79956 (2000). Changes in the standards for administration of clinical tests and examinations, however, would not apply to medical evidence developed before January 19, 2001. 20 CFR § 718.101(b) (2006). The new rules specifically provide that some revisions to Part 725 apply to pending cases, while others (including revisions to the rules regarding modification) do not; for a list of the revised sections which do **not** apply to pending cases, see 20 CFR § 725.2(c) (2006). The U.S. District Court for the District of Columbia upheld the validity of the new regulations in *National Mining Association v. Chao*, 160 F.Supp.2d 47 (D.D.C. 2001). However, the Court of Appeals affirmed in part, reversed in part, and remanded the case. *National Mining Association v. Department of Labor*, 292 F.3d 849 (D.C. Cir. 2002) (Upholding most of the revised rules, finding some could be applied to pending cases, while

others should be applied only prospectively, and holding that one rule empowering cost shifting from a claimant to an employer exceeded the authority of the Department of Labor). On December 15, 2003, the Department of Labor promulgated revisions to 20 CFR §§ 718.2, 725.2 and 725.459 implementing the Circuit Court's opinion. 68 Fed. Reg. 69930 et seq. (2003). In this case, the Claimant filed her claim before the effective date of the new regulations. Accordingly, I will apply only the sections of the newly revised version of Parts 718 and 725 that the court did not find impermissibly retroactive. In this Decision and Order, the "old" rules applicable to this case will be cited to the 2000 edition of the Code of Federal Regulations; the "new" rules will be cited to the 2006 edition.

Pursuant to 20 CFR § 725.310 (2000), in order to establish that she is entitled to benefits, the Claimant must demonstrate that there has been a mistake in determination of fact such that she meets the requirements for entitlement to benefits under 20 CFR Part 718.[1] A surviving spouse is entitled to benefits if the miner died due to pneumoconiosis which arose out of coal mine employment. See 30 U.S.C. § 901; 20 CFR §§ 718.205 and 725.212(a)(3) (2006). The Claimant must first establish that the miner suffered from pneumoconiosis. *See Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993).

ISSUES

The issues contested by the Employer, or by the Employer and the Director, OWCP, are:

1. Whether the Claimant could withdraw her initial claim filed on February 1, 1999.

2. Whether the Miner had pneumoconiosis as defined by the Act and the regulations.

3. Whether his pneumoconiosis arose out of coal mine employment.

4. Whether his death was due to pneumoconiosis.

5. Whether the Claimant is an eligible survivor of the Miner.

6. Whether the evidence establishes a mistake in a determination of fact in a prior denial of the claim pursuant to 20 CFR § 725.310 (2000).

The Employer withdrew the issues of whether the claim was timely filed, whether the Miner was in fact a miner, whether the Employer was properly named as the responsible operator, and whether it was insured. The Employer stipulated that the Miner had 12.5 years of coal mine employment. The Employer reserved its right to challenge the statute and the regulations. DX 210; Tr. 12-13.

[1] As the Miner is deceased, and this is a survivor's claim which was denied based on the medical condition of the Miner, there cannot be a material change in conditions. The case therefore turns on whether there was a mistake of fact in the prior denial of the Claimant's claim.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural Status of the Claims

As noted above in the procedural history, the Claimant in this case has filed two survivor's claims, the first on February 1, 1999. DX 160. This claim was denied by Judge Jansen, whose decision was upheld by the Benefits Review Board on August 24, 2001. The Board's decision became final on the date it was issued pursuant to 20 CFR § 725.502(a)(2). The Claimant filed a motion to withdraw the claim on April 10, 2002, which was granted by the District Director, OWCP. However, the Benefits Review Board later held that a claim may not be withdrawn after it has already been adjudicated and denied. *Clevenger v. Mary Helen Coal Co.*, 22 B.L.R. 1-193 (2002) (en banc); *Lester v. Peabody Coal Co.*, 22 B.L.R. 1-183 (2002) (en banc). Thus I find that the District Director erred when he granted the Claimant's request to withdraw her 1999 claim. The Claimant filed a new claim on June 26, 2002, less than one year after the Board ruled on her prior claim. DX 182. For this reason, I find that the new claim should be treated as a request for modification of the denial of her initial claim.

Factual Background and the Claimant's Testimony

The Claimant testified at the April 4, 2006, hearing, Tr. 16, and at a hearing held on March 7, 2000. DX 181. She and the Miner were married in 1954, and remained married until the Miner's death on January 7, 1999. She has not remarried since the Miner's death. The Claimant has no dependent children. I find that the Claimant is an eligible survivor of the Miner.

According to the Claimant, the Miner worked as a surface miner operating a bulldozer. After work each night, the Miner would come home covered with coal dust. The Claimant observed coal dust in her washing machine after washing the Miner's work clothing. The Miner had lung cancer in his right lung. Prior to the cancer, the Miner was being treated for his breathing problems and was treated for such for approximately 10 years. His treatment included using a Nebulizer, taking breathing treatments, inhalers, and other medications. The Miner used four to five pillow to sleep on at night and only slept about two hours at night. He experience episodes of coughing and wheezing. The Miner was unable to walk long distances or up hills without becoming short of breath. These breathing problems were the reason the Miner left the mines in January 1981. His last coal mine employment was in Kentucky. Tr. 15; DX 81 at 19, DX 2. Therefore this claim is governed by the law of the Sixth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

The Claimant answered interrogatories served by the Employer. DX 187. The Miner was employed by Shamrock Coal Company for three years, from 1979 to 1981. The Miner smoked for 20 years at a rate of two packs per day. She listed Drs. Kennedy, Harrison, Baker and Myers as treating the Miner at some point during the time period beginning in January 1988, until the Miner's death. She stated that Dr. Baker had read a chest x-ray positive for pneumoconiosis, 1/0 in 1996. The Claimant stated that the Miner was hospitalized various times in Mary Breckinridge Hospital.

The Claimant also provided an Affidavit of the Decreased Miner's Condition. DX 186. In that affidavit, the Claimant stated that the Miner suffered from shortness of breath, coughing,

and smothering during sleep. This breathing problem prevented the Miner from doing just about anything. She observed these conditions for several years.

The Claimant alleged that the Miner worked in the mines from 1966 to 1980 or 1981. DX 181, 183. The Miner testified that he worked in the mines for 15 years. DX 81 at 18. The District Director, OWCP, found that he worked in the mines for 12 years between 1966 and 1981. DX 205. The Employer stipulated to 12.5 years at the 2006 hearing, and both parties stipulated to at least 12.5 years at the 2000 hearing. DX 181 (Tr. at 15). I find that the record supports at least 12.5 years of coal mine employment. *See* DX 161 and DX 162.

Based on the Claimant's testimony, the Miner's testimony, and the medical reports, I find that the Miner had a 20-32 year history of smoking 1-2 packs of cigarettes per day, for a total of at least a 40 pack-year history of smoking cigarettes, having quit in 1987.

Medical Evidence

Autopsy

An autopsy may be the basis for a finding of the existence of pneumoconiosis. A finding of anthracotic pigmentation is not sufficient, by itself, to establish pneumoconiosis. 20 CFR § 718.202(a)(2) (2006). Section 718.106(a) provides that an autopsy report shall include a detailed gross macroscopic and microscopic description of the lungs or visualized portion of a lung. If a surgical procedure was performed to obtain a portion of a lung, the evidence should include a copy of the surgical note and the pathology report. Greater weight may be accorded to a physician who performs the autopsy over one who reviews the autopsy slides. *Peabody Coal Co. v. Shonk*, 906 F.2d 264, 269 (7th Cir. 1990); *U.S. Steel Corp. v. Oravetz*, 686 F.2d 197, 200 (3d Cir. 1982); *Gruller v. Bethenergy Mines, Inc*., 16 B.L.R. 1-3 (1991); *Similia v. Bethlehem Mines Corp*., 7 B.L.R.1-535, 1-539 (1984); *Cantrell v. U.S. Steel Corp*., 6 B.L.R. 1-1003, 1-1006 (1984). An autopsy report may be given greater weight than x-ray reports. *Griffith v. Director, OWCP*, 49 F.3d 184, 187 (6th Cir. 1995), citing *Peabody Coal Co. v. Shonk*, 906 F.2d 264, 269 (7th Cir.1990).

Dr. Antonio Abalos performed an autopsy on the Miner. DX 181, DX 198. According to the website of the American Board of Medical Specialties, Dr. Abalos is board-certified in Anatomical and Clinical Pathology. He provided gross macroscopic and microscopic descriptions of the cardiovascular system and the respiratory system. The lungs showed occasional blackish discoloration, but no macules, nodules or emphysema. Dr. Abalos observed a 3cm tumor in the Miner's lung. The microscopic examination also revealed no pneumoconiosis. His final diagnoses were negative for coal miner's pneumoconiosis; pulmonary thromboemboli with pulmonary congestion; 3 cm oat cell carcinoma, right upper lobe; and pulmonary congestion. There were no cardiovascular diagnoses. He did not give an opinion on the cause of death.

Dr. Richard L. Naeye reviewed the Miner's medical records and the autopsy slides, and provided a report dated September 8, 1999. DX 181 (EX 1). Dr. Naeye is a board certified pathologist. He reported 15 years of coal mine employment and a smoking history 1-2 packs of cigarettes a day for 29 years, possibly quitting in 1987. He said the miner died of the complications of a small cell carcinoma that arose in one of his lungs and metastasized to his liver and

bones. He reviewed the autopsy slides of the Miner's lungs. He said there was only a very small amount of black pigment in the lung tissues, no more than is present in the lungs of some non-miners. There was microscopic evidence of chronic bronchitis and mild centrilobular emphysema. There were large masses of small cell carcinoma at several sites, as well as acute lobular pneumonia. Several arteries showed fresh thrombi or emboli. Dr. Naeye opined that there was no evidence of coal workers' pneumoconiosis. He identified two old healed granulomas from an infection. He said that the Miner had a mild airway obstruction due to cigarette smoking, but his emphysema was too mild to cause any measurable impairment in lung function. As a result of his review of the medical records, Dr. Naeye opined that the Miner's death was not due to coal workers' pneumoconiosis; rather it was due to a combination of weakness, recent emboli and acute pneumonia, with underlying metastasized small cell carcinoma resulting from smoking.

Dr. Carlos DeLara examined the autopsy slides from the Miner's lungs on behalf of the Claimant, and prepared a report dated January 26, 2000. DX 181, DX 198. He did not have any clinical history available. Dr. DeLara is board certified in Pathology. DX 181. He said that "[b]oth lungs showed deposits of coal dust with macules formation." He opined that the Miner suffered from "small cell carcinoma with extension to the hilar lymph nodes." Also, he stated that the Miner suffered from "Simple Coal Workers' Pneumoconiosis, which together with the pulmonary thrombosis, (small), congestion and mild edema were contributory factors to the immediate cause of death." A copy of the death certificate which has been altered to add "Black Lung" to Dr. Tannir's assessment of "lung cancer" as the cause of death accompanies the copy of Dr. DeLara's report submitted by the Claimant.[2] DX 198.

Dr. Grover M. Hutchins reviewed the Miner's medical records and 19 histologic slides from the autopsy, 14 of which contained lung tissue, and prepared a report dated February 14, 2000. DX 181 (EX 2). Dr. Hutchins is a board certified pathologist. He reported 14.5 years of coal mine employment and reported a smoking history of one to one and half packs per day for 32 years, stopping in approximately 1987. Dr. Hutchins said that the slides showed a slight amount of coal dust pigment with associated birefringent silicate-type particles, but no macules, micronodules, macronodules, or lesions of progressive massive fibrosis. He said that coal workers' pneumoconiosis was not present. He observed small cell carcinoma. Additionally, Dr. Hutchins reported the presence of a moderate degree of centrilobular and bullous emphysema, and thromboemboli, acute bronchitis, bronchopneumonia, and a healed granuloma. The five slides of heart tissue showed nothing of note. Dr. Hutchins said that Dr. Bushey's report providing the diagnosis of coal worker's pneumoconiosis (described below) was not consistent with the autopsy slides. Overall, Dr. Hutchins opined that the Miner did not suffer from pneumoconiosis and therefore, pneumoconiosis could not have caused or contributed to the Miner's death. He attributed any pulmonary impairment to emphysema. Additionally, he said, the Miner had a widely metastatic small cell carcinoma of the lung. He said that cigarette smoking, not coal dust, was the cause of both the emphysema and the lung cancer.

Dr. Erika Crouch reviewed the autopsy slides from the Miner's lungs, the autopsy report and the death certificate on behalf of the Employer, and prepared a report dated March 2, 2006. EX 3. Dr. Crouch is a Professor of Pathology & Immunology at the School of Medicine, Washington University in St. Louis. The lungs revealed "emphysema, predominately panacinar

[2] The change was written in black ink on a copy of the death certificate. The ink appears similar to the ink on the Claimant's handwritten cover letter which accompanied it. I find that the Claimant altered the death certificate herself. There is no evidence that her counsel was aware that she had done so.

with some bullous changes and some changes of centriacinar emphysema." Multiple sections showed small cell carcinoma with evidence of metastases. There were also foci of acute bronchopneumonia, an area of organizing pneumonia, and multiple recent pulmonary thromboemboli. "[O]nly a mild deposition of irregular black to dark brown particles consistent with coal dust" and "small amounts of material consistent with silicates" were observed. There were also deposits consistent with cigarette smoke. She observed a "single small macular lesions with small amounts of associated fibrous tissue." There were no other dust related structural alterations. There were also findings supporting an impression of old infectious granulomatous disease. Dr. Crouch's overall diagnosis was mild dust deposition and no evidence of pneumoconiosis; mixed patterns of emphysema; small cell carcinoma; areas of acute and organizing pneumonia; recent pulmonary thromboemboli in parenchymal arteries; and old infectious granuloma. Dr. Crouch said that the single small macule identified "is insufficient for a diagnosis of even mild simple coal worker's pneumoconiosis." The Miner's emphysema was not due to coal dust, but rather, to cigarette smoking as "indicated by the predominance of panacinar changes and the absence of any concordance between the sites or amount of dust deposition and the observed emphysema." As a result, she concluded that "occupational dust exposure could not have caused any respiratory impairment or disability and could not have caused, contributed to, or otherwise hasten the patient's death, most likely secondary to complications of lung cancer." She specifically disagreed with the diagnosis of black lung disease in the death certificate.[3]

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in this case.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2000). Any such readings are therefore included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications of physicians who read x-rays in connection with the black lung claims have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH), and/or the registry of physicians' specialties maintained by the American Board of Medical

[3] It appears that Dr. Crouch received a copy of the altered death certificate which accompanied Dr. DeLara's report submitted by the Claimant. As noted above, the original death certificate did not refer to Black Lung.

Specialties.[4] If no qualifications are noted for any of the following physicians, it means that either they have no special qualifications for reading x-rays, or I have been unable to ascertain their qualifications from the record, the NIOSH lists, or the Board of Medical Specialties. Qualifications of physicians are abbreviated as follows: A= NIOSH certified A reader; B= NIOSH certified B reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
07/17/79	DX 15 Amin BCR/B ILO Classification 1/1, 1/2	DX 12 Cole BCR/B ILO Classification 0/0	
08/28/79		DX 23 Quillin	
07/28/80	DX 26 Bushey A ILO Classification 2/2		DX 13 Cole BCR/B Unreadable
08/25/80		DX 26 Clarke A ILO Classification 0/1	
09/09/80	DX 26 Anderson Category II		
10/07/80	DX 26 Wells ILO Classification 1-3 [sic]		
04/23/81		DX 23 Wright A ILO Classification 0/0 DX 23 Felson BCR/B	

[4] NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, Comprehensive List of NIOSH Approved A and B Readers, February 2, 2007, found at http://www.oalj.dol.gov/PUBLIC/BLACKLUNG/REFERENCES/REFERENCE_WORKS/BREAD3_02_07.HTM . Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www.cdc.gov/niosh/topics/chestradiography/breader-list.html. Information about physician board certifications appears on the web-site of the American Board of Medical Specialties, found at http://www.abms.org. The parties were notified at the hearing that I proposed to take judicial notice of physician qualifications listed on the Internet by these organizations, and had no objection to my doing so. Tr. 15.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
09/03/81		DX 14 Cole BCR/B	
09/08/81		DX 24 Spitz BCR/B ILO Classification 0/0 DX 23 Quillin BCR/B ILO Classification 0/0	DX 23 Cornish Negative; normal. DX 25 O'Neill B Normal chest.
12/02/82		DX 24 Spitz BCR/B ILO Classification 0/0	DX 25 O'Neill B Normal chest.
11/16/84	DX 38, 46 Williams A ILO Classification 1/0	DX 42 Spitz BCR/B DX 41 Broudy B DX 31 Marshall B ILO Classification 0/1	
02/10/86		DX 23, 34 O'Neill B	
06/18/86		DX 34 Broudy B	
09/16/86			DX 138 Patel COPD. No active cardiopulmonary disease
08/16/89	DX 55, 135 Myers A ILO Classification 1/1 DX 71 Brandon BCR/B ILO Classification 1/1 DX 69 Bassali BCR/B ILO Classification 2/2 DX 64 Robinette B ILO Classification 1/0	DX 60 Gordonson BCR/B DX 59 Sargent BCR/B DX 58 Sargent BCR/B	
01/04/91	DX 83 Mathur BCR/B ILO Classification 1/2	DX 80 Kim BCR/B DX 76 Halbert BCR/B	
04/01/91		DX 74 Dahhan B	

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
09/27/91			DX 138 Polisetty Upper lungs clear
10/23/91			DX 138 Patel No active cardiopulmonary disease
09/27/91			DX 138 Polisetty Upper lungs clear. Minimal discoid atelectatic changes in lung bases.
10/23/91			DX 138. Patel Some interstitial lung changes. No active cardiopulmonary disease.
06/11/92	DX 158 Harrison B ILO Classification 1/0 or 1/1		
02/14/96	DX 117, 135 Baker B ILO Classification 1/0	DX 122 Barrett BCR/B DX 118 Sargent BCR/B	
06/18/96		DX 127 Sargent BCR/B DX 130 Barrett BCR/B DX 126 Scott BCR/B DX 125 Dahhan B	
06/27/96		DX 126 Wheeler BCR/B	
03/17/97			DX 163 Gomez Underlying scarring in the right lung. No acute cardiopulmonary process.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
05/14/97			DX 157, 164 Harrison Pleural thickening.
11/28/97			DX 157 Daley No acute cardiopulmonary process. Mild changes of COPD suspected.
02/13/98			DX 154, 157, 164 Harrison Interstitial disease, no acute pulmonary parenchymal infiltrate.
06/12/98			DX 157 Daley Infiltrate on right lobe. Underlying mass cannot be excluded.
06/19/98			DX 165 Daley Extensive infiltrate in and atelectasis with volume loss of the right lung related to known carcinoma.
06/21/98			DX 165 Daley Infiltrate and atelectasis in right lung associated with malignant mass.
06/22/98			DX 165 Polisetty Infiltrate in right lung slightly improved.
06/25/98			DX 165 Daley Infiltrate in right lung improved.
07/27/98	DX 150 Bushy A ILO Classification 2/1	EX 4 Wheeler BCR/B	

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
08/06/98			DX 165 Polisetty Improved infiltrate in right lung with some chronic fibrotic changes remaining in right upper lung which may represent residual mass.
10/02/98			DX 165 Pampati Right lobe infiltrate. Atelectatic changes in right lung.
10/04/98			DX 165 Polisetty Patchy infiltrate and atelectatic changes in right lung
10/07/98			DX 165 Polisetty Chronic infiltrate right upper lobe
12/16/98			DX 164 Datu Mass lesion has almost completely reverted to normal with minimal prominence still seen. Linear fibrosis upper lobe region with decrease in volume of the right lung field consistent with previous radiation therapy changes. Clear left lung field.
12/17/98			DX 165 Daley Increasing right upper lobe atelectasis with suggestion of ill-defined mass. Streaky infiltrate is suspected.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
12/21/98			DX 165 Pampati Infiltrate in right lung – improved since 12/17/98.
12/29/98			DX 165 Polisetty Chronic atelectatic changes with loss of volume in the right lung.

CT Scans

CT scans may be used to diagnose pneumoconiosis and other pulmonary diseases. The regulations provide no guidance for the evaluation of CT scans. They are not subject to the specific requirements for evaluation of x-rays, and must be weighed with other acceptable medical evidence. *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-33-1-34 (1991). A CT scan of the Miner's chest and abdomen was taken on October 27, 1998, in connection with his treatment for lung cancer. The impression of the interpreting radiologist, Dr. Pampati, included evidence of a soft tissue mass density in the right chest, and liver and bone metastasis. There was no mention of coal workers' pneumoconiosis. DX 165.

Medical Opinions

Medical opinions are relevant to the issues of whether the miner had pneumoconiosis, and whether pneumoconiosis caused the miner's death. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2006). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2006). The cause of death must be proved by competent medical evidence. 20 CFR § 718.205(c) (2006). The record contains the following medical opinions relating to this case.

Treatment Records

The Miner and the Employer submitted records of the Miner's treatment at Mary Breckinridge Hospital from 1973 to 1991. DX 123, DX 135, DX 138. The Miner was treated for various problems at an out-patient clinic and as an in-patient. Only records relevant to his pulmonary condition are addressed here.

Pulmonary function testing conducted on July 17, 1979, at Mary Breckinridge Hospital did not result in values qualifying for disability. The form on which the results were reported did not identify the Miner by name, or the physician requesting the tests. It indicated that the patient's age was 42, and that he was a current smoker, having smoked 1.5-2 packs per day for 20 years.

A progress note dated October 22, 1980, indicates that the Miner was seen in follow-up to an emergency room visit for palpitations. The etiology was unclear, but the doctor who saw him believed that his symptoms might be due to cigarettes and coffee. He advised the Miner to switch to decaffeinated coffee, and curtail his smoking. The Miner also discussed his claim for black lung benefits, and requested that a B reading of his x-ray be performed. DX 138.

Dr. James Santacroce saw the Miner beginning in October 1982. According to the American Board of Medical Specialties, Dr. Santacroce is board certified in Internal Medicine. The Miner was admitted to the hospital from October 17-24, and November 1-4, 1983, under the care of Dr. Santacroce. On both occasions, the Miner complained of chest pain. On the first visit, he was described as a pack a day smoker, recently up to about 2.5 packs. His discharge diagnoses included angina and chronic obstructive pulmonary disease (COPD). When he returned on November 1, he said he had quit smoking. His discharge diagnoses on November 4 included unstable angina, peptic ulcer disease with duodenitis and reflux esophagitis, and COPD. DX 138.

Dr. Santacroce saw the Miner in follow-up at the out-patient clinic on November 11, 1983. His chest pain was assessed as probable angina. A stress test was equivocal, but considered positive. The Miner was seen several more times for his chest pain in 1983 and 1984. The Miner's shortness of breath was thought to be due to heart problems. Dr. Santacroce's last note was dated August 24, 1984. Beginning on September 24, 1984, the Miner was seen at the out-patient clinic by Dr. Joaquin Valdes, also a board-certified internist. DX 138.

On May 6, 1985, Dr. Valdes' progress note indicated that he saw the Miner in follow-up for his COPD, which was described as stable. Dr. Valdes saw the Miner for his COPD twice in 1985 (May and June), and three times in 1986 (January, May and June). Each time, the Miner's COPD was described as stable. Dr. Valdes urged the Miner to stop smoking. DX 138.

After Dr. Valdes' progress notes from June 1986, the record contains an x-ray report dated September 16, 1986, the results of which are reported on the table above. Then there is a gap in the Mary Breckinridge out-patient treatment notes until several visits and two x-rays taken in 1991. The Miner was reported to have mild COPD, and doing well on medication, except for an exacerbation in September 1991. DX 123, DX 135, DX 138.

The Miner was under treatment by Dr. Harry R. Kennedy from November 1986, until his diagnosis for lung cancer in June 1998. DX 123, DX 135, DX 140, DX 163. According to the website of the American Board of Medical Specialties, Dr. Kennedy is board certified in Internal Medicine. Office visit notes indicate that the Miner was seen about every other month from 1986 to 1989, then more frequently from 1990 to 1992, returning to about six times a year from 1993 to 1996, and then again with increasing frequency in 1997. Chest examinations frequently revealed scattered rhonchi, sometimes, scattered expiratory wheezing, and, occasionally, basilar crackles. Dr. Kennedy's diagnoses included COPD, chronic or acute bronchitis, chronic

emphysema, pulmonary fibrosis, arteriosclerotic cardiovascular disease and hypertensive cardiovascular disease.

The Miner was referred to Dr. John M. Harrison for evaluation of his COPD on June 11, 1992. DX 154, DX 158. According to the web-site of the American Board of Medical Specialties, Dr. Harrison is board-certified in Internal Medicine and Pulmonary Disease. According to the NIOSH list, he was a B reader from September 1986 to September 1998. He took medical, family, social and occupational histories, conducted a physical examination, and administered a chest x-ray and pulmonary function testing. He reported 15 years of coal mine employment. He reported a smoking history of 1.5 – 2 packs per day for 32 years prior to quitting 5 years before the examination. Physical examination revealed diffuse expiratory wheezes. Chest x-ray revealed some interstitial markings consistent with coal workers' pneumoconiosis, category 1/0 or 1/1, and resolving pneumonia. Pulmonary function testing was invalid due to poor effort. Dr. Harrison diagnosed COPD, "not that severe … [but] quite prominent for bronchospasm," with multiple episodes of acute bronchospasm requiring hospitalization, possibly exacerbated by reflux and a history consistent with sleep apnea. Chest examination revealed expiratory wheezes. He placed the Miner on a regimen of bronchodilator therapy and scheduled a sleep study and an upper G.I.

Dr. Harrison saw the Miner in follow-up on July 17, 1992. The sleep study did not show obstructive apnea. The results of the upper G.I. were not yet available. His impression was that the Miner's COPD seemed fairly well controlled, and that he may have reflux disease. He planned to see the Miner again in six months. DX 154, DX 158.

The Miner next saw Dr. Harrison on May 14, 1997. The Miner reported that in the intervening years since his previous visit, he had been treated by Dr. Kennedy. He complained of a number of episodes of extremely severe shortness of breath, and left-sided chest pain. On examination, his lungs were clear. Dr. Harrison diagnosed mild COPD. He did not think that it was responsible for the Miner's severe episodes. He suspected severe underlying coronary artery disease, and recommended a cardiology workup. DX 154, 157, 158, 164.

When the Miner returned to Dr. Kennedy on June 6, 1997, Dr. Kennedy reported that his recent heart catheterization was unrevealing. DX 163.

The Miner visited Dr. Harrison again on August 15, 1997. DX 154, DX 158. Dr. Harrison said that the Claimant's cardiac evaluation revealed only non-obstructive plaque, but did show atrial arrhythmia for which medication was prescribed. Dr. Harrison's impression was COPD with a history of a bronchospastic component, but only a mild obstruction shown on pulmonary function testing. Dr. Harrison thought his condition might be affected by reflux disease. He planned to see the Miner in six months.

The Miner was hospitalized at the Mary Breckinridge Hospital under the care of Dr. Roy Varghese from November 28-29 1997, for an exacerbation of his COPD. According to the web-site of the American Board of Medical Specialties, Dr. Varghese is board certified in Internal Medicine. Diagnoses included a history of COPD, COPD and black lung. Dr. Varghese saw the Claimant again on follow-up on February 5, 1998. DX 157, 163.

Dr. Harrison saw the Claimant on February 13, 1998. Dr. Harrison noted that he had been following the Miner for COPD with a history of a bronchospastic component. The Miner had only mild obstruction on pulmonary function testing, and his diffusion capacity was normal. He was doing quite well when last seen in August 1997. The Miner reported that since then, he was having increased shortness of breath and had been hospitalized under the care of Dr. Varghese. Dr. Harrison took an x-ray, and thought the Miner might have early pneumonia, which he treated with medication. DX 154, 157, 158, 164.

Thereafter, the Miner noted rapid weight loss, and diffuse aches and pains, making it difficult for him to walk. He also had increasing shortness of breath. The Claimant was hospitalized at the Mary Breckinridge Hospital from June 8-13, 1998, again under the care of Dr. Varghese, who diagnosed pneumonia, a mass in the right apex suggestive of carcinoma, COPD and thrombocytopenia. DX 157, 163.

On June 13, 1998, the Miner was transferred to Central Baptist Hospital. Dr. Harrison performed a bronchoscopy with bronchial washings on June 15, 1998. An intended biopsy could not be performed because the Miner developed severe respiratory distress during the procedure. Dr. Harrison diagnosed lung cancer from the results of the bronchoscopy. DX 157, 164. On June 18, 1998, the Claimant transferred to the Hazard-ARH Hospital (ARH) under the care of Dr. Nizar Tannir. According to the American Board of Medical Specialties, Dr. Tannir is board certified in Internal Medicine, Hematology and Medical Oncology. A catheter was placed for administration of chemotherapy, and the Miner was discharged home on June 26, 1998. Discharge diagnoses included extensive stage small cell carcinoma of the lung with liver metastases, post-obstructive pneumonia, pancytopenia and chronic obstructive pulmonary disease. DX 165.

Dr. Harrison saw the Miner on August 21, 1998. At that time he had been treated by Dr. Tannir with three courses of chemotherapy, and the Miner wanted Dr. Harrison to check him and answer his questions. DX 164.

The Claimant was again admitted to ARH on August 5, October 2, November 16, December 16, and December 28, 1998, under the care of Dr. Hassan Ghazal, an oncologist and hematologist, and Dr. Tannir, each time for complications and discomforts associated with his cancer and attendant treatment, such as pneumonia, chest pain, which was found not to be heart-related, anemia, and nausea and vomiting. DX 165.

Dr. Tannir signed the Miner's death certificate. He identified lung cancer as the immediate cause of death, with no other underlying or contributing causes. DX 181.

Opinions Given in Connection with the Black Lung Claims

A form entitled "Attending Physician's Statement" bears an illegible signature dated March 3, 1981. The form states that the Miner had chronic bronchitis and coal workers' pneumoconiosis. Symptoms first appeared on May 1, 1980, and the patient first consulted the physician on October 7, 1980. He had been seen four times. According to the form, the Miner became totally disabled on February 3, 1981.

Dr. J.D. Lewis examined the Miner on behalf of the Department of Labor on August 18, 1979. DX 10. His credentials are not in the record, and although there are several doctors with the same initials and last name listed on the web-site of the American Board of Medical Specialties, I cannot determine whether he is listed there. He recorded the Miner's symptoms and medical history, and conducted a physical examination. He reported a smoking history of two packs per day for 8-10 years. The chest examination revealed distant breath sounds (but noting an obese chest), with fine inspiratory rales scattered in the bases. He diagnosed obesity, hyperventilation versus angina, and COPD. He marked a box indicating that the Miner's COPD was due to coal dust exposure, but put a question mark next to the box added, "possibly—2 PPD Smoker." He said the Miner had a moderate toward minimal impairment.

Dr. Harold L. Bushey examined the Miner on July 28, 1980. DX 26. His qualifications are not in the record, and he is not listed on the web-site of the American Board of Medical Specialties. According to the NIOSH list, he is an A reader. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, and pulmonary function testing. He reported a history of 15 years of coal mine employment. He reported that the Miner used to smoke two packs each day, and cut back to one pack a year before the examination. The chest examination revealed an increased AP diameter, decreased breath sounds, and a tight cough. The chest x-ray revealed opacities consistent with pneumoconiosis, 2/2. Dr. Bushey diagnosed coal workers' pneumoconiosis based upon the x-ray evidence. He said the Miner should avoid further exposure to dust.

Dr. William Anderson examined the Miner on August 8, 1980, at the request of his counsel. DX 26. Dr. Anderson is a Professor of Medicine in the Division of Respiratory and Environmental Medicine at the University of Louisville. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, and pulmonary function testing. He reported a history of 14 years of coal mine employment. He said that the Miner began smoking at the age of 18 at a rate of one pack per day and was still smoking at the time of the examination. The chest examination was normal. The chest x-ray revealed Category II Pneumoconiosis. He did not provide the details of the pulmonary function testing, or tracings, but reported that the Miner's FEV_1 was 90% of predicted. Dr. Anderson diagnosed hypertensive cardiovascular disease and Category II Occupational Pneumoconiosis.

Dr. Robert Matheny examined the Miner on or around September 26, 1980. DX 26. According to the website of the American Board of Medical Specialties, Dr. Matheny is board certified in Internal Medicine and Pediatrics. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, and pulmonary function testing. He reported that the Miner spent 14 years in coal mine employment. He reported that the Miner had smoked one pack per day for 23 years. The chest examination revealed bilateral distant breath sounds and a few inspiratory and expiratory wheezes. The chest x-ray revealed opacities consistent with pneumoconiosis, profusion 1/1 to 1/2. He did not comment on the pulmonary function testing, but reported results indicating that the Miner did not qualify for disability on that account; the Miner's FEV_1 was 70% of predicted. Dr. Matheny opined that the Miner suffered from pneumoconiosis, COPD-emphysema, and hypertension. He did not comment on the etiology of the Claimant's COPD.

Dr. B. H. Wells examined the Miner on October 7, 1980 and prepared a report dated February 6, 1981. DX 26. He took occupational, social, family and medical histories, and

conducted a physical examination, chest x-ray, EKG, and an exercise tolerance test. Dr. Wells reported 14 years of coal mine employment. The chest examination revealed rhonchi and wheezing in both bases. The chest x-ray revealed pneumoconiosis, category 1-3. Dr. Wells reported that the Miner became very short of breath after the exercise tolerance test. Overall, Dr. Wells diagnosed coal workers' pneumoconiosis and chronic bronchitis. Dr. Wells wrote a letter dated February 6, 1981, addressed "To Whom It May Concern," in which he stated, "Due to this patient's heart and lung condition, I feel that [it] is dangerous both to himself and others for him to operate any type of heavy equipment. He is totally unable to do any form of manual labor." DX 26.

Dr. Ballard Wright examined the Miner on April 23, 1981, and was deposed on July 7, 1981, in connection with the Miner's state workers' compensation claim. DX 23. Dr. Wright is board certified in Anesthesiology. He took occupational and medical histories, and conducted a physical examination, chest x-ray, EKG, and pulmonary function and arterial blood testing. He reported 15 years of coal mine employment. He reported a smoking history of one pack per day for 26 years. The chest examination was normal, finding no rales, wheezing, or rhonchi. The chest x-ray was negative for pneumoconiosis, 0/0. Pulmonary function studies showed no evidence of obstructive or restrictive impairment. A depression of arterial oxygen at rest normalized with exercise. Dr. Wright opined that the Miner did not suffer from pneumoconiosis.

Dr. Charles Hieronymus examined the Miner on September 3, 1981and November 16, 1984, at the request of his counsel. DX 26, DX 30, DX 31. Dr. Hieronymus is board certified in Family Practice. DX 45. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, and pulmonary function testing. A 15-year coal mine employment history was reported. The chest examination revealed decreased breath sounds and clubbing of the nail beds. The chest x-ray revealed coal workers' pneumoconiosis, 1/2. Dr. Hieronymus' overall diagnosis was coal workers' pneumoconiosis, COPD, and small airway disease. Additionally, he opined that the Miner was totally disabled due to pneumoconiosis. Dr. Hieronymus was deposed on May 2, 1986. DX 45. At his deposition, he said that the pulmonary function studies showed significant deterioration in the Miner's condition between 1981 and 1984. He agreed that weight gain such as that by the Miner could affect one's pulmonary function test results, but said that it would be reflected in restrictive rather than obstructive results. The Miner had obstructive disease.

Dr. Allen Cornish examined the Miner on September 8, 1981 in connection with his state workers' compensation claim, prepared a report dated September 15, 1981, and was deposed on October 15, 1981. DX 23. Dr. Cornish is a board certified internist. He took occupational, social, family and medical histories, and conducted a physical examination. He reported that the Claimant worked in the mines for 15 years. He reported a smoking history of one pack per day for 20 years. The chest examination was normal. The chest x-ray was negative for pneumoconiosis. The pulmonary function and arterial blood gas studies were normal. Overall, Dr. Cornish opined that the Miner did not suffer from pneumoconiosis. He said there was no objective evidence of pulmonary disability. His only diagnosis was obesity.

Dr. Richard O'Neill examined the Miner on behalf of the Employer on August 12, 1981 and February 10, 1986. DX 23, DX 34. Dr. O'Neill prepared a report of the first examination on August 12, 1981, and was deposed on September 8, 1991. DX 23. Dr. O'Neil is board certified in internal medicine in Ireland and Britain, and chest diseases in the United States. DX 23. He

took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, EKG, blood gas studies and pulmonary function testing. He reported 14.5 years of employment as a strip miner, working a bull dozer. He reported a smoking history of one-half of a pack per day for the past three to four years, previously having smoked one pack per day for most of his adult life. The chest examination was normal. There was no peripheral cyanosis or digital clubbing. The chest x-ray was negative for any evidence of pneumoconiosis, 0/0. The pulmonary function studies and arterial blood gas studies were normal. Overall, Dr. O'Neill opined that the Miner did not suffer from pneumoconiosis, and did not suffer from any pulmonary impairment. He opined that the Miner suffered from chronic bronchitis, history of hypertension, syncope of undetermined origin, and peptic ulcer, and obesity. It was his opinion that the Miner could return to his work in the coal industry. He thought the major cause of the Miner's bronchitis was cigarette smoking, but that a minor cause was inhalation of noxious dusts. He attributed the Miner's shortness of breath and non-specific chest pain to obesity and hypertension.

Dr. Broudy examined the Miner on behalf of the Employer on June 18, 1986. He also reviewed the report of Dr. O'Neill's examination. DX 34. Dr. Broudy is board certified in Internal Medicine and Pulmonary Disease. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, EKG, blood gas studies and pulmonary function testing. He reported 15 years of coal mine employment. He reported that the Miner smoked. The chest examination was normal. The chest x-ray was negative for pneumoconiosis. The pulmonary function and arterial blood gas studies were both normal. Overall, Dr. Broudy opined that the Miner did not suffer from pneumoconiosis or any pulmonary impairment arising from coal mine employment. He said that the normal testing suggested that the Miner's dyspnea was non-pulmonary in origin.

Dr. John E. Myers, Jr., examined the Miner at the request of his counsel on August 16, 1989. DX 55, 135. Dr. Myers is board certified in Internal Medicine, and an A reader. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He reported that the Claimant worked in the mines for 15 years. He reported a smoking history of one to one and half packs per day for thirty years, quitting in 1987. Chest examination was normal. Dr. Myers read the x-ray as showing coal workers' pneumoconiosis, 1/1. The pulmonary function test was normal. The arterial blood gas study was normal. Dr. Myers diagnosed coal workers' pneumoconiosis. He found no impairment of the Miner's lungs, but said the Miner would be disabled due to other medical conditions.

Dr. A. Dahhan examined the Miner on April 1, 1991, on behalf of the Employer, and prepared a report dated April 23, 1991. DX 74. Dr. Dahhan is board-certified in Internal Medicine and Pulmonary Disease, and a B reader. Dr. Dahhan said there was insufficient objective evidence for a diagnosis of occupational pneumoconiosis. He diagnosed mild COPD due to cigarette smoking. He opined that the Miner did not suffer from a pulmonary or respiratory disability. He based his opinion on the medical records and the pulmonary function and arterial blood gas studies. He said that some of the Miner's symptoms could be caused by his heart medications and overweight.

Dr. Gregory Fino reviewed the Claimant's medical records and provided a report dated April 23, 1991. DX 80. Dr. Fino is a board-certified in internal medicine and pulmonary

disease, and a B reader. Dr. Fino opined that the Claimant had no pulmonary or respiratory impairment based on the results of the valid pulmonary function tests and arterial blood gas studies. He also found that the Claimant did not have pneumoconiosis.

Dr. Stephen Kiteck was one of the Miner's treating physicians who practiced with Dr. Kennedy. He prepared an attending physician's statement of disability seeking an insurance premium waiver based on totally disabling chronic lung disease, dated November 26, 1990, listing the Miner's diagnosis as COPD and pulmonary fibrosis. He also prepared letters on behalf of the Miner dated January 9, 1989 and April 9, 1991, stating that the Miner was under his care for chronic lung disease which had to be treated with long term medication. Finally, also on April 9, 1991, he completed a questionnaire indicating he had treated the Miner from November 1986 to March 11, 1991, that the Miner had severe chronic lung disease, and that he was unable to perform his past work activity or other work. DX 72, 73, 135.

Dr. Glen Baker examined the Miner on February 14, 1996, at the request of his counsel. DX 117, 135. Dr. Baker is board certified in Internal Medicine and Pulmonary Disease, and a B reader. He took occupational, social, family, and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He reported that the Claimant worked in the mines for 15 years. He reported a smoking history of one pack per day for 30 years. The chest examination revealed bilateral inspiratory and expiratory wheezes. Dr. Baker read the x-ray as showing coal workers' pneumoconiosis, 1/0. The pulmonary function test showed moderately severe obstructive disease. The arterial blood gas study revealed mild hypoxemia at rest. Dr. Baker diagnosed coal workers' pneumoconiosis, mild resting arterial hypoxemia, and bronchitis. He did not comment on the etiology of the hypoxemia or the bronchitis.

Dr. Dahhan examined the Miner a second time on behalf Employer on June 20, 1996, and reviewed his medical records from the black lung claims, including his own prior report. DX 125. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He reported that the Claimant worked in the mines for 15 years. He reported a smoking history of one pack per day for 29 years. The chest examination revealed "reduced air entry to both lungs with bilateral expiratory wheeze and prolongation of the expiratory phase. No crepitation or pleural rubs are audible." Dr. Dahhan read the x-ray as showing no pneumoconiosis, 0/0. The pulmonary function tests were performed with less than optimal effort showed moderate obstructive impairment, mild air trapping and a mild diffusion defect. DX 128. The arterial blood gas study was normal at rest and with exercise. Dr. Dahhan diagnosed COPD due to cigarette smoking. He said there had been a mild worsening in the Miner's obstructive impairment shown by the pulmonary function studies. He said that the impairment did not result from his history of coal mine employment. DX 125.

Dr. James Castle reviewed the Miner's medical records, including treatment records, and records from his black lung claims, and provided a report dated January 14, 1997, on behalf of the Employer. DX 137. Dr. Castle is board-certified in Internal Medicine and Pulmonary Disease, a B reader. Dr. Castle opined that the Miner did not have coal workers' pneumoconiosis. He said that the Miner worked in the mines long enough to develop pneumoconiosis in a susceptible person. The Miner also had a 29-45 pack-year smoking history, sufficient to cause COPD. He also had symptoms of allergies and asthma, which can contribute to COPD.

Dr. Castle observed that the Miner had multiple episodes of variability in his breathing, affected by fumes, perfumes, odors, and damp weather. He said this was typical of a patient suffering from allergic bronchial asthma, although the Miner was never given that diagnosis. Findings in the medical records were not consistent with an interstitial process. The Miner's symptoms were periodic, as would be seen with asthma and tobacco induced COPD. The majority of B readers found no radiographic evidence of pneumoconiosis. Early valid pulmonary function tests and arterial blood gas studies were essentially normal, and later tests showed only mild abnormalities. In his opinion, the Miner suffered from COPD due to cigarette smoking, and allergic bronchial asthma.

Dr. Bushey examined the Miner a second time on July 27, 1998, at the request of his counsel. DX 150. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, and pulmonary function testing. He reported that the Miner worked in the mines for 15 years. He reported that the Miner smoked off and on, but quit in 1976. He noted that the Miner had recently been found to have small cell cancer of the lung and was undergoing chemotherapy. Chest examination revealed decreased breath sound, and an increased AP diameter. He interpreted a chest x-ray as positive for pneumoconiosis, 2/1. Based upon his examination, Dr. Bushey concluded that the Claimant was suffering from coal worker's pneumoconiosis, COPD with pulmonary fibrosis and lung cancer.

Dr. Rosenberg reviewed the Miner's medical records on behalf of the Employer, including treatment records, the autopsy report, and medical reports given in connection with the Miner's black lung claims, and provided a report dated March 8, 2006. EX 1. Dr. Rosenberg is board-certified in Internal Medicine, Pulmonary Disease, and Occupational Medicine. EX 5. He concluded that the Miner died with metastatic carcinoma of the lung, having had a long a significant smoking history, and many years of treatment for COPD. He noted that there was no restrictive disease, and the Miner's obstructive disease demonstrated near normalization after administration of bronchodilators in the Miner's last set of pulmonary function tests. He said that the autopsy protocol revealed no evidence of coal workers' pneumoconiosis; he credited Dr. Naeye's conclusion that any black pigment in the lungs did not meet the minimal criteria to establish a diagnosis of pneumoconiosis. Dr. Rosenberg opined that the Miner did not have legal or clinical pneumoconiosis. The Miner had centrilobular emphysema, which was caused by smoking, and not coal dust exposure. Dr. Rosenberg opined that the Miner died from lung cancer and stated that "coal mine dust exposure is not considered a carcinogen." He opined that the Miner's death "would have occurred in a similar fashion, irrespective of his past coal mine dust exposure." Furthermore, Dr. Rosenberg found that the Miner's death was not "hastened or accelerated by any COPD he had." EX 1 at 9-10.

Dr. Vuskovich reviewed the Miner's medical records on behalf of the Employer, including the Miner's treatment records and autopsy report, and provided a report dated March 8, 2006. EX 2. Dr. Vuskovich is a board-certified in occupational medicine and a B reader. EX 6. Neither the x-rays nor the CT scans indicated any evidence of pneumoconiosis. The pulmonary function studies were more indicative of asthma than other types of COPD or pneumoconiosis. Dr. Vuskovich found that the autopsy did not demonstrate any evidence of coronary artery disease, chronic bronchitis or emphysema. Based on the Miner's history of treatment for allergies, Dr. Vuskovich believed that the Miner had the adaptive immune system condition atopy. He thought the Miner was misdiagnosed as having heart disease and cigarette-induced COPD, but did have asthma, a reversible form of COPD. He opined that the Miner died from a

pulmonary embolus, as reported in the autopsy results. The Miner had three important risk factors for pulmonary embolus, his age, cancer and obesity. A pulmonary embolus is "unrelated to coal workers' pneumoconiosis and it is unrelated to occupational coal dust exposures." In the opinion of Dr. Vuskovich, the Miner died from a complication of his lung cancer.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or 'clinical,' pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2006). In this case, the Claimant's medical records indicate that he was diagnosed with chronic obstructive pulmonary disease and bronchitis, which can be encompassed within the definition of legal pneumoconiosis. Ibid.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal mine dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003); 65 Fed. Reg. 79938 (2000) ("The Department reiterates … that the revised definition does not alter the former

regulations' … requirement that each miner bear the burden of proving that his obstructive lung disease did in fact arise out of his coal mine employment, and not from another source.").

Twenty CFR § 718.202(a) (2006) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in Sections 718.304 (irrebuttable presumption that a miner's death was due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners who died on or before March 1, 1978), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that the Claimant had a lung biopsy. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, the Claimant filed her claim after January 1, 1982, and the Miner died after March 1, 1978. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the autopsy, the chest x-rays, the CT scan and the medical opinions. As this claim is governed by the law of the Sixth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at Section 202(a). *See Cornett v. Benham Coal Co.*, 227 F.3d 569, 575 (6th Cir. 2000); *Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Autopsy evidence is the most reliable evidence of the existence of pneumoconiosis. *Peabody Coal Co. v. McCandless*, 255 F.3d 465 (7th Cir. 2001); *Terlip v. Director, OWCP*, 8 B.L.R. 1-363 (1985). The autopsy was performed by Dr. Abalos, a board certified pathologist. In his autopsy report, Dr. Abalos described the appearance of the lungs and heart as a whole. He also performed both macroscopic and microscopic examination of the lungs and heart. He said that the lungs sowed occasional blackish discoloration, but no macules, nodules or emphysema. He opined that the Miner's lungs were negative for pneumoconiosis. Rather, they showed pulmonary thromboemboli and oat cell carcinoma. Dr. Abalos documented the observations supporting his diagnosis.

Four board certified pathologists reviewed the Dr. Abalos' report and slides from the autopsy. Three of the four, Drs. Naeye, Hutchins and Crouch, agreed with Dr. Abalos that the Miner did not have pneumoconiosis. All three had access to additional clinical information about the Miner's medical history. All three agreed that there was a small amount of coal black or coal dust pigment in the Miner's lungs, but none observed any macules or nodules except for

Dr. Crouch, who observed just one, but said that it was not sufficient for a diagnosis of coal worker's pneumoconiosis. All three observed emphysema, but did not diagnose legal pneumoconiosis.

Only Dr. DeLara diagnosed clinical pneumoconiosis. He reviewed only the autopsy slides and report. He did not have the Miner's clinical history. His description of what he saw in the autopsy slides was dramatically different than any of the other pathologists. He stated that the lungs showed formation of macules; that the Miner suffered from simple coal workers' pneumoconiosis; and that pneumoconiosis was a contributing factor to the Miner's death. Dr. DeLara's description of the slides is in direct conflict with other physicians who observed, at most, only one macule. Dr. DeLara's analysis is conclusory, and he does not sufficiently explain his observations or give any basis to credit his conclusions over those of other physicians who reviewed the slides and came to the opposite conclusion. He had less information about the Miner's medical history than the other pathologists. I find that his opinion is not as well documented and reasoned as those of the other physicians who rendered opinions, and therefore accord it less weight. I find that the Claimant has failed to establish the presence of pneumoconiosis based on the autopsy evidence.

Chest x-rays available in this case have been read as positive or negative, or both positive and negative. For cases with conflicting x-ray evidence, the regulations specifically provide,

> … where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2006); *Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31, 1-37 (1991). Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52.

There are many interpretations of x-rays taken during treatment which made no reference to pneumoconiosis. Whether an x-ray interpretation which is **silent** as to pneumoconiosis should be interpreted as **negative** for pneumoconiosis, is an issue of fact for the ALJ to resolve. *Marra v. Consolidation Coal Co.*, 7 B.L.R. 1-216 (1984); *Sacolick v. Rushton Mining Co.*, 6 B.L.R. 1-930 (1984). I find that the early x-rays read as normal or negative (taken in 1981 and 1982) were negative for pneumoconiosis. Later x-rays, beginning in 1986, except for two taken in 1991, all reflected abnormalities including COPD, atelectatic changes, interstitial changes, scarring, pleural thickening, and a right lung malignant mass. I find these x-rays were neither positive or negative for pneumoconiosis.

X-rays read for pneumoconiosis were taken between 1979 and 1998. I find that a few of the x-rays, mostly taken earlier in time, were either positive, or in equipoise due to opposite readings by equally qualified readers. Those x-rays were taken in July 1979 (in equipoise); July,

September, and October 1980 (all positive); August 1989 (in equipoise); and June 1992 (positive). However, I find that the following x-rays were negative for pneumoconiosis due to only negative readings by well qualified readers, or negative readings outweighing positive readings because better qualified readers found them to be negative: August 1979 (only negative); August 1980 (only negative); April and September 1981 (three x-rays, all read only as negative); December 1982 (only negative); November 1984 (better qualified readers found it to be negative); February and June 1986 (both only negative); January (negative readings by two dually qualified readers outweigh positive reading by one dually qualified reader) and April (only negative) 1991; February (negative readings by two dually qualified readers outweigh positive reading by one B reader) and June (only negative) 1996; and July 1998 (negative reading by dually qualified reader outweighs positive reading by A reader). Thus there are 6 x-rays which are positive or in equipoise, and 14 x-rays which are negative. The two most recent x-rays are negative for pneumoconiosis. Looking at the x-ray evidence as a whole, I find that the weight of the x-ray evidence is negative for pneumoconiosis. Moreover, my conclusion that the x-ray evidence is negative is consistent with the negative autopsy evidence, while the positive readings are undermined by the autopsy evidence.

The CT scan performed in 1998 in connection with the Miner's treatment for lung cancer confirmed the presence of lung cancer with metastases, but the reader made no mention of pneumoconiosis or COPD. The CT scan does not support a finding of pneumoconiosis, either.

I must next consider the medical opinions. The Claimant can establish that the Miner suffered from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (*en banc*). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co*., 6 B.L.R. 1-1182, 1-1184 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as the Claimant's treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence …" *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate

cases, a treating physician's opinion may be give controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 CFR § 718.104(d) (2006). The Sixth Circuit has interpreted this rule to mean that:

> … in black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade … For instance, a highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinions appropriately discounted. The case law and applicable regulatory scheme make clear that ALJs must evaluate treating physicians just as they consider other experts.

Eastover Mining Co. v. Williams, 338 F.3d 501, 513 (6th Cir. 2003) (citations omitted).

The Miner's treatment records disclose that he was diagnosed and treated for COPD, generally characterized as "mild" in recent years, with occasional exacerbations, along with various other medical conditions. Although the Miner's heart was a suspected cause of his symptom of shortness of breath, testing did not confirm any serious heart condition. The Miner's family doctor, Dr. Kennedy, referred to chronic or acute bronchitis, emphysema and pulmonary fibrosis. Another physician who practices with Dr. Kennedy and prepared statements in support of the Miner's disability claims, Dr. Kiteck, said that the Miner had severe chronic lung disease and was disabled, but did not state what caused the disease or the disability; nor did he state the basis for his opinion other than the fact that he was a treating physician. However, the progress notes indicate that the Miner was usually seen by Dr. Kennedy, who indicated that the Miner's reported symptoms exceeded what he observed in the office. Occasional references to black lung or pneumoconiosis in hospital records appear to be based on the Miner's reports of his medical history, rather than contemporaneous diagnosis. I give greater credence to the opinion of the Miner's pulmonologist, Dr. Harrison, as to the Miner's pulmonary status, because of his greater expertise, and his familiarity with the Miner's pulmonary condition during the last two years of his life. He diagnosed COPD with bronchospasm, but did not attribute the COPD to any particular etiology. Nor did he diagnose either clinical or legal pneumoconiosis. Dr. Harrison also diagnosed lung cancer. Dr. Tannir, an oncologist, had substantial responsibility for the Miner's cancer treatment, and signed the death certificate. He identified lung cancer as the cause of death. Like Dr. Harrison, he did not mention pneumoconiosis.[5] I conclude that the Miner's treatment records do not support a finding that the Miner had either clinical or legal pneumoconiosis.

Numerous medical opinions were obtained by the parties in connection with the Miner's and the Survivor's claims. The basis for the attending physician's statement from 1981 cannot be determined. As it is not documented or reasoned, I give it no weight. 13 doctors examined the Miner 17 times in connection with his black lung claims between 1979 and 1996. Of those, 7 diagnosed clinical pneumoconiosis based on positive x-ray readings (Drs. Bushey, Anderson, Matheny, Wells, Hieronymous, Myers, and Baker). However, I have determined that the autopsy evidence is negative for clinical pneumoconiosis, as well as the weight of the x-ray

[5] As noted above, a copy of the death certificate found in DX 198 was altered to add Black Lung as a cause of death. There is no credible evidence, however, that Dr. Tannir believed that black lung disease played any role in the Miner's death.

evidence. As a result, I do not credit their opinions. Two doctors, Drs. Lewis and O'Neill, suggested that exposure to coal dust may have contributed to the Miner's COPD or bronchitis, which would constitute a diagnosis of legal pneumoconiosis. Dr. Lewis' credentials are not known, his opinion was given very remote in time, and his opinion was equivocal at best. I give it little weight. Dr. O'Neill specializes in diseases of the chest. I find that his opinions are documented and reasoned, and give them probative weight. However, it appears that the Miner underreported his smoking history to Dr. O'Neill, and his examinations were also remote in time. These factors undermine Dr. O'Neill's opinion.

Arrayed against the opinions of Drs. Lewis and O'Neill that the Miner had legal pneumoconiosis, are the opinions of four examining physicians (Drs. Wright, Cornish, Broudy, and Dahhan), as well as the opinions of four physicians who reviewed his medical records (Drs. Fino, Castle, Rosenberg, and Vuskovich). Six of these physicians (not Drs. Wright and Cornish) are board certified in pulmonary disease and/or occupational medicine, adding to the weight to be given to their opinions. Dr. Wright is board certified in Anesthesiology, while Dr. Cornish is board certified in Internal Medicine and focuses on heart and lung problems in his practice. Dr. Cornish's qualifications therefore approach those of the pulmonologists and occupational health specialists, who have the strongest qualifications, while Dr. Wright's do not. All eight of the negative opinions are documented and reasoned. Dr. Lewis saw the Miner in 1979. Dr. O'Neill saw him in 1981 and 1986. Drs. Wright and Cornish examined the miner in 1981, Dr. Broudy in 1986, and Dr. Dahhan in 1991 and 1996. Dr. Fino reviewed the Miner's records in 1991, Dr. Castle in 1997, and Drs. Rosenberg and Vuskovich in 2006. The more recent reports are entitled to greater weight as they more accurately reflect the Miner's condition during the later years of his life. In addition, a medical opinion which is supported by more extensive documentation is entitled to greater weight than an opinion based on more limited medical data. *Sabett v. Director, OWCP*, 7 B.L.R. 1-299, 1-301 n. 1 (1984). Drs. Rosenberg and Vuskovich were able to consider the autopsy report as well as treatment and examination records, and thus had the greatest documentation available to them. Access to the autopsy findings is particularly important in this case. For this reason, the opinions of Drs. Rosenberg and Dr. Vuskovich are entitled to the greatest weight.

After weighing all of the medical opinions of record, I resolve the conflict by according greater probative weight to the opinions of Drs. Rosenberg and Vuskovich than to those of Drs. Lewis and O'Neill. Both possess excellent credentials in the field of pulmonary disease. Both had access to the most evidence regarding examinations and treatment of the Miner, his condition at the end of his life, and the autopsy data. I also find their reasoning and explanation in support of their conclusions more complete and thorough than that provided by either Dr. Lewis or Dr. O'Neill. Drs. Rosenberg and Vuskovich better explained how all of the evidence they reviewed, including the autopsy evidence, supported their conclusion. I also find the opinions of Drs. Rosenberg and Vuskovich to be in better accord both with the evidence underlying their opinions, and the overall weight of the medical evidence of record. Further, additional credibility is lent to their finding that the Miner did not have pneumoconiosis by the detailed and reasoned opinions rendered by Drs. Wright, Cornish, Fino, Broudy and Dahhan. In the final analysis, I find that the Claimant has failed to establish that the Miner had pneumoconiosis on the basis of medical opinion evidence.

The autopsy evidence, the x-ray evidence, the treatment records, and the medical opinions given in connection with the claims, weighed separately or together, are not sufficient

to establish that the Miner had pneumoconiosis. Nor has the Claimant shown its presence by any other means. I find that the Claimant has failed to meet her burden of showing that there was a mistake in a determination of fact on this issue in the prior denial of her claim. Because the Claimant has failed to show that the Miner had pneumoconiosis, she cannot show that she is entitled to benefits under the Act.

Death Due to Pneumoconiosis

Even were I to find that the Miner had pneumoconiosis, the claim would still fail, because the evidence does not establish that his death was due to pneumoconiosis. In claims filed after January 1, 1982, death will be considered to be due to pneumoconiosis if (1) competent medical evidence establishes that the miner's death was due to pneumoconiosis; (2) pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis; or (3) the presumption set forth at 20 CFR § 718.304 applies, i.e., an irrebuttable presumption that death was due to pneumoconiosis where there is medical evidence of complicated pneumoconiosis; but not if (4) the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death. 20 CFR § 718.205(c) (2006). The Sixth Circuit, in which this claim arises, has held that any condition that hastens the miner's death is a substantially contributing cause of death. *Brown v. Rock Creek Mining Corp.*, 996 F.2d 812 (6th Cir. 1993); *Peabody Coal Co. v. Director, OWCP*, 972 F.2d 178, 183 (7th Cir. 1992); *Northern Coal Co. v. Director, OWCP*, 100 F.3d 871, 874 (10th Cir. 1996). This principle has now been codified in the regulations at 20 CFR § 718.205(c)(5) (2006). Nevertheless, a claimant must still prove that pneumoconiosis has "hastened" death by a "a specifically defined process that reduces the miner's life by an estimable time"; the basis for finding that pneumoconiosis contributed to a miner's death may not be simply that the disease made a miner weaker and, thus, less resistant to some other trauma that directly caused the death. *Eastover Mining v. Williams*, 338 F.3d 501, 517-518 (6th Cir. 2003).

In this case, the oncologist who treated the Miner during his final illness certified that his death was caused by lung cancer, and identified no other contributing causes. The only evidence that pneumoconiosis hastened the Miner's death was the opinion of Dr. DeLara, a pathologist. I have found his opinion to be less well documented and reasoned than those of the other pathologists, Drs. Naeye, Hutchins, and Crouch, who came to the opposite conclusion. Drs. Rosenberg and Vuskovich, the pulmonologists who reviewed the autopsy data along with the Miner's treatment and examination records, were also of the opinion that pneumoconiosis did not cause, contribute to or hasten the Miner's death. Dr. Rosenberg also specifically stated that the Miner's COPD did not hasten his death. Even had I found that the Miner's COPD constituted legal pneumoconiosis, I would also have credited Dr. Rosenberg's opinion on this point as well.

I find that the Claimant has failed to establish that pneumoconiosis caused the Miner's death within the meaning of the statute and regulations. It follows that she has failed to establish a mistake of fact in the prior denial of her claim. As a result, she is not entitled to Black Lung benefits.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to meet her burden to establish that there was a mistake in a determination of fact in the prior denial of her claim, or that the Miner had pneumoconiosis, or that his death was due to pneumoconiosis, she is not entitled to benefits under the Act.

ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to her in pursuit of this claim.

ORDER

The request for modification filed by the Claimant on June 26, 2002, is hereby DENIED.

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ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the Administrative Law Judge's Decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the Administrative Law Judge's Decision is filed with the District Director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC, 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC, 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the Administrative Law Judge's Decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).